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SUBMISSION TO THE STANDING COMMITTEE OF THE LEGISLATURE ON SOCIAL DEVELOPMENT

NOVEMBER 1993

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EXECUTIVE SUMMARY

Introduction:

This Submission has been prepared as a joint presentation representing fifteen of the twenty-four healthcare professions to be regulated under the **Regulated Health Professions Act (RHPA).** The views and recommendations expressed in this Submission represent the consensus of these associations. Several of the associations who are members of the Coalition also intend to appear before the Committee to present their respective views on issues or concerns other than those raised in this Submission.

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In addition to preparing this Submission, the Coalition has acted as a catalyst and facilitator for discussions on Bill 100 with victims and survivors[1] of sexual abuse by healthcare practitioners, their representatives, government officials, MPP's, the regulatory boards and with other groups and individuals concerned about Bill 100 specifically, or about sexual abuse generally.

Background:

Professional healthcare associations and their members have gone through a difficult and evolutionary awakening process in coming to grips with the true extent and impact of sexual abuse by health care practitioners. Coalition members admit that we have been slow to respond to the problem. We have not been alone. The regulatory boards, governments, other professions and society-at-large have been tardy in grappling with the problem of sexual abuse in our society.

Part of the problem has been the hidden or secret nature of the offence and the understandable reluctance on the part of victims to come forward. Another part of the problem has been that only

recently has broad-based, empirical research helped to define the extent of sexual abuse in the healthcare sector and the magnitude of its impact on victims. Some of what we now know has been generated by the healthcare associations and regulatory Colleges themselves, in Ontario and elsewhere.[2]

What was traditionally thought to be a problem of microscopic proportions is now realized to be much larger. Having been insufficiently aware of and insensitive to the problem for too long, regulated healthcare associations now want very much to be a real partner in the solution.

It was with this philosophy that the Coalition approached Bill 100. The Coalition endorses legislation and other action to counter sexual abuse by professionals in unbalanced power relationships. The Coalition endorses severe penalties for healthcare practitioners found guilty of sexually abusing patients. The Coalition emphasizes perhaps the obvious, however: Sexual abuse is a societal problem. It is not isolated to the regulated healthcare sector. As a societal problem, it requires a comprehensive solution. Notwithstanding, the Coalition accepts that the healthcare sector is as good a place to start as any, but Bill 100 should be perceived only as a first step towards resolution of a society-wide problem.

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Accordingly, the Coalition very much wants to help make Bill 100 as effective as possible in achieving the objectives we all share:

- deterring sexually abusive behaviour by healthcare practitioners;
- identifying and punishing abusive healthcare practitioners;
- ensuring that the investigative and disciplinary process is fair and balanced and does not continue the victimization of the complainant; and

- ensuring that victims have access to adequate funding for therapy and counselling .

When evaluated against those objectives, the Coalition believes that Bill 100 either falls short of or misses the mark in the following areas:

- In order to be effective, Bill 100 must be and be seen to be reasonable, fair, balanced, comprehensible and not unduly intrusive.

- Bill 100 does not hit the right balance to maximize reporting. As a consequence, Bill 100 falls short in correcting the fundamental and pervasive problem of under-reporting, which is critical to the success of the legislation.

- The Bill falls short in ensuring that the costs of treatment for victims and survivors will be reasonably and fairly apportioned, in ensuring that victims and survivors receive the quality treatment they deserve and that adequate funds will be available.

The Coalition also wishes to emphasize that legislation and regulatory actions alone will not suffice. Education and communication within the healthcare sector, within professions, with victims' and survivors' groups, with patients and the public generally are absolutely essential.

It is also critical that justifiable repugnance at sexually abusive healthcare practitioners should not be used to legitimize the erosion of long-established civil rights and the principles of natural justice in the investigative and disciplinary processes established to handle complaints.

Furthermore, it is critical that Bill 100 not set in motion the laws of unintended consequences that compromise the patient-practitioner

relationship, or that otherwise act to the detriment of our healthcare system.

Recommendations:

The Coalition has decided to limit the issue areas addressed in this Submission and to restrict its recommendations to five generic areas: the definition of sexual abuse (Section 3), mandatory reporting by professionals (Section 18), intervenor status (Section 7), the Therapy and Counselling Fund (Subsection 85.7) and the general issue of grafting Bill 100 on to the RHPA.

Definition of Sexual Abuse

(See pages 14 through 24 of Submission)

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The Coalition is very concerned at the feasibility of having a single definition of sexual abuse adequately cover all twenty-four groups covered by the RHPA, the myriad procedures and treatments used by those twenty-four groups and the vast range of patient-practitioner relationships that exist, not only across the gamut of regulated groups but also within professions.

The definition proposed by Bill 100 does not address the issue of consent, the assessment of harm, when a person becomes or ceases to be a "patient" and the issue of intent. The Coalition also feels subsection 3(4) goes too far in authorizing extensions to the definition by regulation. The Coalition agrees that the "clarification" power contemplated by subsection 3(4) is essential to allow each College to adapt to the single definition to the circumstances and requirements of each profession, but any extensions to the definition should remain the prerogative of the Legislature, subject to full public scrutiny and debate.

The Coalition proposes an amended definition with three clearly-

defined categories of sexual abuse (reflecting the government's original proposals),[3] that includes what we call the "exploitation formula" to get at the issue of intent and that introduces "harm" as a criterion in the "touching" and "behaviour and remarks" categories. The Coalition also wishes it made clear that consent - real or inferred - should not be a defence against a charge of sexual abuse.

The proposed amendments are as follows:

3. *In this Code, a member is guilty of a sexual offence with respect to a patient* ***if there is any exploitation by a member of the practitioner/patient relationship, by the member's words or actions, in any of the following ways:***

   a) ***"sexual violation"****, namely sexual intercourse or other forms of physical sexual relations between the member and a patient.*

   b) ***"sexual transgression"****, namely touching, of a sexual nature, of a patient by the member* ***that causes harm*** *to that patient; or*

   c) ***"sexual impropriety"****, namely behaviour or remarks of a sexual nature by the member towards the patient* ***that causes harm*** *to that patient.*

Mandatory Reporting by Professionals

(See pages 24 through 30 of the Submission)

The effectiveness of Bill 100 will depend in large part on the extent to which health professionals accept and effect their reporting requirements. Problems likely to inhibit professional reporting arise in three areas:

- Inter-Professional reporting. The approach set out in Bill

100 requires a high degree of knowledge of one profession of the regulations of another. That is simply unrealistic and raises the potential for inter-professional misunderstandings;

- Reporting by treating professionals. The Bill 100 approach implies breaching patient-practitioner confidentiality, and will deter self-referral by practitioners. Furthermore, revealing incidents of sexual abuse during treatment could be taken as a "confession" by the accused practitioner; and

- Reporting by practitioners generally.

The most problematic category for mandatory reporting is in the "behaviour and remarks" category, although the "touching" category also raises problems, particularly with respect to inter-professional reporting. In the "behaviour and remarks" category, the Coalition proposes substitution of the "duty to intervene".

The Coalition also proposes striking the phrase "... obtained in the course of practising the profession ..." to impose a wider responsibility on practitioners.

The proposed amendments are as follows:

85.7 A member who has reasonable grounds to believe that another member of the same (or a different) College has been guilty of an offence of sexual impropriety[4] as defined by Section 1, Schedule 2(3), has a duty, acting reasonably, in good faith and in the best interests of the patient, to intervene forthwith by:

a) meeting the member to admonish that member to cease such behaviour, to apologize to the patient, to seek counselling, or to take such other remedial action as the member may consider warranted under the circumstances; and/or

b) offering to mediate between the member and the patient; and/or

c) advising the patient of his or her rights to file a report with the Registrar of the College of the other member; and/or

d) filing a report in accordance with section 85.3.

Intervenor Status

(See pages 30 to 34 of Submission)

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Victims and survivors believe, with some justification, that the current investigative/disciplinary process minimizes or marginalizes their impact and, in some respects, continues their victimization. The Coalition wants to see a disciplinary/investigative process that is fair and equitable to both the complainant and the accused, that is flexible, expeditious and not unnecessarily vulnerable to judicial override. The Coalition fears that Bill 100's approach to non-party participation risks doing exactly the opposite.

The Coalition proposes that Section 7 be amended to restrict the participation of non-party intervenors to those who satisfy the accepted legal test of relevance:

- with respect to assisting in the panel's determination of guilt or innocence; or

- to assist or represent victims and survivors who are minors or mentally incompetent; or

- with respect to assisting the panel in assessing the emotional or physical harm sustained by the victim upon a finding of guilt; or

• with respect to assisting the panel in determining the appropriate penalty or penalties following a find ing of guilt and in light of the harm caused and the particular circumstances at play.

Therapy and Counselling Fund

(See pages 34 through 40 of the Submission)

The Coalition believes as a fundamental point that funding for counselling and therapy should be available to victims of sexual abuse in unbalanced power relationships wherever they occur in society. It is ridiculous to believe or imply that the phenomenon exists only or largely in the healthcare sector. The Coalition suggests that funding be incrementally expanded to cover all professionals regulated by the Ontario government.

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Funding supported by additional levies on the innocent healthcare practitioners is opposed by the Coalition. It is a departure from the principal of universal, no-fault healthcare. It is an unwarranted and dangerous extension of the collective professional responsibility of healthcare practitioners. It will not assure adequate funding across the range of Colleges and professions. It places Colleges in a real or perceived conflict of interest. It may also result in an erosion of the principles and objectives underlying the RHPA, by encouraging some healthcare practitioners to leave regulated practice.

The Coalition is particularly concerned about funding for therapy and counselling in the unregulated sector, where no or minimal standards of practice and accountability exist and where treatments could well be therapeutically useless or damaging to the patient.

The Coalition recommends:

a) that there be one Fund for the treatment of victims and survivors of sexual abuse by healthcare practitioners and that a single Fund cover all healthcare sectors;

b) that the Fund be financed from general government revenues;

c) that a single expert board administer allocations from the Fund to persons upon a finding that said persons were victims of sexual abuse while a patient of a healthcare practitioner;

d) that treatment or counselling of a victim by an unregulated healthcare practitioner not be eligible for funding, in whole or in part, from the Fund; and

e) that disbursements from the Fund could retroactively cover treatment and counselling obtained prior to a panel's determination of guilt.

Stand-Alone Legislation

(See pages 40 through 41 of the Submission)

Throughout its Submission, the Coalition points out problems raised by merging the sexual abuse legislation with the RHPA. These problems include limiting application of the legislation to the healthcare sector--and the regulated healthcare sector at that; the ability and credibility of the self-governing regulatory structure and process to handle complaints; real or perceived conflicts in Colleges both investigating and adjudicating complaints and making disbursements from the Therapy and Counselling Fund and so on.

The Coalition recommends:

- that Bill 100 be separated from the **Regulated Health Professions Act** and go forward and be proclaimed as an Act in its own right; and

- that a clause be added to Bill 100 requiring its referral to a Standing Committee of the Legislature for review and public hearings within two (2) years of Proclamation of Bill 100.

In this way, furthermore, Bill 100 could be used as a base to build an effective legislative regime to counter sexual abuse by a range of provincially-regulated, self-governing professionals (e.g. teachers, social workers, police, lawyers, the clergy etc.)

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ENDNOTES

1. See page 3 of the Submission ("A Note on Terminology") for an explanation of the Coalition's decision to use the phrase "victims and survivors".

2. See, for example, The Task Force Report on Sexual Abuse of Patients by Physicians commissioned by the CPSO (1991), a survey by Environics Research commissioned by the OMA (1991), a Canada Health Monitor Survey commissioned by the CPSO (1991) and the Report of the Committee on Physician Sexual Misconduct commissioned by the B.C. College of Physicians & Surgeons (1992).

3. Ministry of Health position paper "Taking Action Against Sexual Abuse".

4. Assumes acceptance of the Coalition's recommendations on the definition of sexual abuse.

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PART I

Introduction

This submission to the Standing Committee of the Legislature has been prepared by the ad hoc Coalition of Regulated Healthcare Associations on Bill 100 (the Coalition) in response to referral to the Standing Committee on Social Development of an Act to amend the Regulated Health Professions Act, 1991 (Bill 100). The members of the Coalition are associations representing healthcare practitioners who will be regulated under the **Regulated Health Professions Act, 1991** (RHPA) upon Proclamation of that Act. Invitations to be part of the Coalition were extended to each association representing the twenty-four healthcare groups to be regulated by the RHPA. The majority of associations chose to come together in an ad hoc Coalition; others took positions or directions at variance with those of the Coalition; some, even though in agreement with Coalition positions, decided to maintain their autonomy.

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The fifteen members of the Coalition are:

The Ontario Society of Chiropodists
The Ontario Chiropractic Association
The Ontario Dental Hygienists' Association
The Denturist Association of Ontario
The Ontario Dietetic Association
The Ontario Massage Therapist Association
The Ontario Medical Association
The Ontario Association of Medical Radiation Technologists
The Ontario Association of Registered Nursing Assistants
The Ontario Society of Occupational Therapists
The Ontario Association of Optometrists
The Ontario Physiotherapy Association
The Ontario Podiatry Association
The Ontario Psychological Association
The Ontario Association of Speech-Language Pathologists and Audiologists

Together, these associations represent over 51,000 professional healthcare practitioners and students across Ontario.

Each of the associations now forming the Coalition has, at varying times over the past years, initiated educative and other actions to address the issue of sexual abuse. Each association reviewed the report of the independent Task Force on Sexual Abuse of Patients established by the Ontario College of Physicians and Surgeons[1] and participated in the consultations with the Ministry of Health that ensued after the Report was released in 1992; and after release of the Ministry of Health position paper "Taking Action Against Sexual Abuse of Patients"[2]. Where possible, each association also worked with its regulatory board in response to advice from the Minister of Health[3] that each College develop a policy and action plan to address sexual abuse of patients.

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After tabling of Bill 100 on November 25, 1992, however, several associations decided to initiate consultations with other associations to share concerns, experiences and ideas. The first meeting was held on January 6, 1993 and was attended by fifteen associations. Out of that meeting came the ad hoc Coalition.

The Coalition's mandate is to act as a forum of healthcare associations for the discussion and debate of Bill 100 and the issues it raises.

The Coalition has also acted as a catalyst and facilitator for discussions with, and to convey the associations' collective views and concerns to, government officials, MPP's, groups or persons representing victims and survivors of sexual abuse by healthcare practitioners, the regulatory boards and other groups or associations concerned about the issue of

1. The Task Force on Sexual Abuse of Patients by Physicians was commissioned in January, 1991. The Task Force released a preliminary report in May, 1991 and a final report in November, 1991.

2. Released on October 8, 1992.

3. See letter dated November, 1991, from Frances Lankin, MPP, Minister of Health, sent to each governing body.

sexual abuse. [A list of the groups or persons consulted by the Coalition or consultations attended by the Coalition is attached to this Submission at Annex A.]

A Note on Terminology

".... this interminable wrestle with words and their meanings....."
T.S. Eliot

In preparing this Submission the Coalition had to wrestle with the sensitive issue of terminology. Does one refer to patients who have been sexually abused by healthcare practitioners as "victims", as "survivors", or as a combination of both? The choice is laden with sensitivity because each word has been, or can be, ascribed meanings and inferences that are at the base of often emotional discussions on sexual abuse.

At first, the Coalition had thought the term "victim" would be an apt and descriptive word, because sexually abused patients have been victimized, both by practitioners and by the disciplinary system. The Coalition, in this Submission, also wanted to recognize those patients who have not come forward with a complaint of sexual abuse, for whatever reason, and who therefore continue to be victimized. On the other hand, however, the Coalition recognizes that many groups eschew the term "victim" because it is seen by them to carry a stigma of on-going helplessness and powerlessness.

"Survivor" appears to be the term of choice for most patients, or groups who represent patients, who have been sexually abused.

The Coalition understands that "survivor" clearly implies that the person has survived, is no longer a powerless victim and has taken, or is prepared to take, their individual destiny in their own hands. The

term "survivor" is, however, resisted by some groups in this context because they feel that it trivializes their or their forbearers' history of survival under horrendous conditions, be it through the Holocaust, the extermination camps of Pol Pot or the current events in the former Yugoslavia. Such groups characterize themselves, officially or otherwise, as "survivors".

In the final analysis the Coalition decided to use both terms "victim(s)" and "survivor(s)". This is more than a political compromise. It reflects the fact that there are both victims and survivors; that there is a continuum of victim to survivor through which at least some sexually abused patients progress. It is also a reflection of the Coalition's belief that people and groups, within reason, have the right to call themselves whatever they wish.

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In its own way, this discussion over terminology has been a learning process in the import and impact of words in the context of sexual abuse and the potential for honest misunderstandings among people of goodwill.

PART II

Background

Sexual abuse is not a new phenomenon in our society. Sexual abuse of patients by healthcare practitioners is not a new phenomenon. Because of the nature of the abuse, it infrequently comes to public attention. Furthermore, until recently the subject of sexual abuse by healthcare practitioners has been less discussed and researched than other areas of human interaction. What research there was tended to focus on mental health therapists. As a consequence, there has been a level of awareness of, or attention to, the problem substantially less than it deserved.

"...there has been a level of awareness of or attention to the problem substantially less than it deserved."

Healthcare practitioners, their associations and regulatory boards have gone through a difficult and evolutionary awakening process in coming to grips with the true extent and impact of sexual abuse of patients by healthcare practitioners. We were not alone. Government officials, society at large, even victims and survivors and their representatives have only recently begun to define the true extent of the problem and the magnitude of the impact on abused patients. Some of what we now know about the subject has been generated through some of the associations and Colleges. The Canada Health Monitor Survey commissioned in 1991 by the Ontario College of Physicians and Surgeons[4] and a subsequent survey commissioned by the Ontario Medical Association[5] were instrumental in defining the scope of the problem at least as it related to physicians and surgeons.

"Government officials, society at large, even victims and their representatives have only recently begun to define the true extent of the problem and the magnitude of the impact on abused patients."

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4. "Initial Analysis of a Survey of Ontario Women regarding Sexual Harassment and Abuse by Ontario Physicians" (October 27, 1991). The CPSO commissioned the Canada Health Monitor to carry out a "pilot study" with respect to the experiences of women patients in Ontario with their physicians. The purpose of the study was to assess the extent of women's experience of sexual harassment and abuse by physicians.

5. The Survey was performed by Environics Research Inc. and released in December, 1991. It covered seven issue areas of relevance to OMA members, each with its own set of questions and included four questions arising from the government's Task Force on Sexual Abuse of Patients: the level of physicians' awareness of the task force report; whether the report had increased physicians' awareness and sensitivity about sexual abuse (51% said "yes"); whether physicians agreed with permanent loss of license as a penalty for sexual abuse; physicians' opinion on reporting colleagues suspected of sexual abuse; and the level of support for OMA/CPSO education programs.

The Report of the Committee on Physician Sexual Misconduct commissioned by the College of Physicians & Surgeons of British Columbia[6] has become another landmark in the learning process and in the development of appropriate and effective responses, largely because of the original research that went into preparation of the Report and, incidentally, the identification of certain areas requiring further research and investigation.

"Professions and regulatory boards have also had to come to grips with the serious and lasting harm to patients whose relationship of trust and vulnerability with a healthcare practioner has been exploited and abused."

What was traditionally thought to be a problem of microscopic proportions is now realized to be much larger. Professions and regulatory boards have also had to come to grips with the serious and lasting harm to patients whose relationship of trust and vulnerability with a healthcare practitioner has been exploited and abused.

While it has always been generally assumed that sexual relations between practitioner and patient do harm to the patient, only recently has empirical research defined the extent and nature of that harm. In studies by Pope and Bouhoutsos[7], for example, that are quoted at some length in the B.C. College of Physicians & Surgeons Report, patients equated sexual relationships with their treating psychotherapists as being akin to rape, a "kind of incest" and a clear violation of the trust relationship into which the patients thought they had entered.

"The informal discussions and the formal consultations organized around Bill 100 by the Ontario Ministry of Health with victims and survivors and their groups have been very instructive and helpful."

The informal discussions and the formal consultations organized around Bill 100 by the Ontario Ministry of Health with victims and survivors and their groups have been very instructive and helpful. They have been instrumental in the educative process, particularly in understanding the impact of sexual abuse on individual patients. They have also been invaluable in exploring areas of commonality and searching for consensus.

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6. "Crossing the Boundaries", The Report of the Committee on Physician Sexual Misconduct, prepared for the College of Physicians & Surgeons of British Columbia, (November, 1992).

7. Pope, Kenneth S. and Bouhoutsos, Jacqueline, **Sexual Intimacy Between Therapist and Patients**, Praeger, New York, 1986.

Each member of the Coalition clearly recognizes that any behaviour that abuses the relationship of trust between patient and practitioner, or that exploits a patient's vulnerability, is completely unacceptable. Each member of the Coalition now recognizes that the extent of sexual abuse and its impact on patients call for concerted action. Having been unaware of and, therefore, part of the problem, Coalition members want to be part of the solution.

"Each member of the Coalition clearly recognizes that any behaviour that abuses the relationships of trust between patient and practitioner, or that exploits a patient's vulnerability, is completely unacceptable."

In evaluating Bill 100, the Coalition has raised the following issues:

- It is the basic, underlying intent of Bill 100 to identify and punish abusive practitioners and to deter abusive behaviour. The Coalition feels that Bill 100 could be made more workable in the achievement of these objectives.

"Each Member of the Coalition now recognizes that the extent of sexual abuse and its impact on patients call for concerned action."

- Sexual abuse generally and sexual abuse of patients by practitioners have always been gravely "under-reported". Will Bill 100, as drafted, correct the fundamental and pervasive problem of under-reporting? The Coalition thinks not.

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"Having been unaware of and, therefore, unwittingly been a part of the problem, Coalition members want to be part of the solution."

- In order to be effective, particulary in mandatory reporting which is critical to the success of the legislation, the Bill has to be, and be seen to be, reasonable, fair, balanced and comprehensible. Is this the case with Bill 100? The Coalition thinks not, in several important areas.

- Will Bill 100 assure that the costs of treatment for victims and survivors of abuse will be reasonably and fairly apportioned, that victims and survivors will receive the quality treatment they deserve and that sufficient funds will be available for treatment? The Coalition thinks not.

- Bill 100 applies only to the regulated healthcare sector. What about the already large and growing unregulated sector where no, or minimal, standards and accountability exist? What about other non-healthcare professional groups where similar "power imbalances" exist in the professional/client relationships?

"What about the already large and growing unregulated sector where no, or minimal, standards and accountability exist?"

The central motivation of the Coalition, therefore, is our members' collective judgement that Bill 100, as currently drafted, will not be as effective as it could be in achieving its objectives or in addressing the wider issue of sexual abuse in our society. Coalition members acknowledge that the healthcare professions have been, usually through omission but also through commission, party to the very serious problem of sexual abuse and want very much to be part of the process to solve it. With that in mind, it is the Coalition's objective, through this Submission, to identify problem areas it sees in the Bill and to suggest changes to enhance the workability of Bill 100.

"What about other non-healthcare professional groups where similar "power imbalances" exist in the professional/client relationships?"

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A First Step ...

The Coalition views Bill 100 as an important first step - but only a first step - towards an effective legislative regime and regulatory framework to counter sexual abuse by healthcare practitioners. Bill 100 is far from perfect. It would be unreasonable, however, to expect new legislation on such a difficult, complex and contentious subject to achieve perfection first time around. The Coalition sees Bill 100 as the beginning point on a legislative process and feels it absolutely essential that the legislative and regulatory regime be periodically examined and progressively improved in light of experience.

At the same time, however, the Coalition is committed to helping make the first step (Bill 100) as effective as possible.

The Need for Education and Communication ...

"There must be more by way of public education and communication to help healthcare consumers better understand that which constitutes acceptable and unacceptable practioner behaviour, what patients' rights are and the requirements of the law."

"Another important initiative is continuation of the consultations among associations, Colleges, victims and survivors and victims' and survivors' groups to continue our education."

The Coalition is also strongly of the opinion that legislation and regulation alone will not root out incidents of sexual abuse. Behavioral patterns that lead to incidents of sexual abuse are deeply entrenched in society. These behaviour patterns must be changed, but will change only through education and communication. Education about offensive behaviour patterns and sexual abuse must become a part of every healthcare practitioner's formal education and training. The regulatory boards and healthcare associations must ensure continued education and sensitization of their memberships after registration. There must be more by way of public education and communication to help healthcare consumers better understand that which constitutes acceptable and unacceptable practitioner behaviour, what patients' rights are and the requirements of the law. One initiative worthy of consideration is a "patients' Bill of Rights" that clearly sets out and explains the rights of patients and the obligations of healthcare practitioners. Another important initiative is continuation of the consultations among associations, Colleges, victims and survivors and victims' and survivors' groups to continue our education. To date, these consultations have been invaluable at the leadership level of the regulatory boards and associations in exchanging ideas and informing and sensitizing. The next stage is to extend that process to board association members, individual practitioners and to the public.

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An argument could be made that, until now, associations have not done enough to educate and sensitize their memberships about sexual abuse. In fact, many associations have initiated education programs. More could be done and there is a growing commitment among association members to do more.

The government, victims and survivors and their representatives should appreciate, however, that over the past several years health-care associations have had to respond to a virtual blizzard of new legislative, regulatory and policy initiatives from government.[8] Responding to these initiatives has required enormous commitments of time and resources by the associations, many of which are small with few, if any, permanent staff.[9] The resources needed to devise and implement membership and public communications programs and to set up and attend conferences and seminars on sexual abuse are simply not available for many associations within their already-strained resources.

Balancing Rights ...

"The Coalition does not oppose severe penalties for healthcare practioners found guilty of sexually abusing a patient. The Coalition recognizes that the nature of the offence and the devastating effect sexual abuse usually has on patients call for severe penalties against the abuser."

It is readily apparent to each member of the Coalition that the penalties contemplated by Bill 100 are severe. For those who are found guilty of sexual abuse there will be monetary fines up to a maximum of $35,000.00 plus all or a portion of the costs of counselling for the survivor, the College's legal costs and expenses sustained during the investigation and hearing of the complaint and temporary or permanent revocation of the offending practitioner's licence to practice, not to mention embarrassment, professional censure and community ostracism. The $35,000.00 fine alone amounts to three and-a-half times the maximum penalty authorized for incompetence or professional misconduct under the **Health Professions Procedural Code.**

The Coalition does not oppose severe penalties for healthcare practitioners found guilty of sexually abusing a patient. The Coalition recognizes that the nature of the offence and the devastating effect sexual abuse usually has on patients call for severe penalties against the abuser.

8. For example, (at the provincial level alone) the RHPA exercise including the on-going regulation-making exercise, the **Consent to Treatment Act, Advocacy Act**, proposed amendments to the **Public Hospitals Act,** the Expenditure Restrain program and the Social Contract, the OHIP Review, Long-Term Care Reform, the Southwestern Ontario Comprehensive Health System Planning Commission, etc.

9. The Coalition membership spans associations having annual budgets ranging from a low of $35,000.00 to over $10 million. Some of the smaller and less well-financed associations are precisely those that face some of the greatest educative and communications challenges with respect to the subject of sexual abuse.

But it must be borne in mind that the extra-legal penalties are also severe for any practitioner who is accused of sexually abusing a patient and subsequently found to be innocent: Community and professional censure caused by public and media attention, negative implications for the practice, the cost of mounting a defence, family tensions and the inability to completely obliterate the stain of a false accusation even when innocence has been determined.

"The Coalition also recognizes that past victims and survivors of sexual abuse by healthcare practitioners have been denied their rights, both through the incident of sexual abuse and also too often through the regulatory boards' investigative and disciplinary procedures."

The Coalition also recognizes that past victims and survivors of sexual abuse by healthcare practitioners have been denied their rights, both through the incident of sexual abuse and also too often through the regulatory boards' investigative and disciplinary procedures.

"Given the severity of the penalties and the need to safeguard civil rights - for both guilty and innocent parties - it is critical that any legislation and regulatory framework be even-handed..."

Given the severity of the penalties and the need to safeguard civil rights - for both guilty and innocent parties - it is critical that any legislation and regulatory framework be even-handed; that the principles of natural justice be applied; and that the rights of the complainant be equitably and reasonably balanced with the rights of the accused. The principles of natural justice, the evidentiary rules, the presumption of innocence until proven guilty, the right of both sides to be heard and so on have evolved over centuries to protect and safeguard the rights of accused and complainant, of the innocent and guilty alike.

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"Rebalancing of rights is achieved by strengthening the rights of one party, not by diminishing the rights of the other."

Procedurally, the handling of reports and the course of disciplinary actions relating to accusations of sexual abuse must be above reproach. Justifiable repugnance at professionals who commit sexual abuse should not be allowed to justify an erosion of these long-established rights. Rebalancing of rights is achieved by strengthening the rights of one party, not by diminishing the rights of the other. Legislation which is seen to be excessively punitive, one-sided, overly intrusive and that erodes long-established civil rights, will attract neither the respect nor credibility essential for compliance.

Sexual Abuse as a Societal Issue ...

While in no way trying to diminish or to draw attention away from the issue of sexual abuse by regulated healthcare practitioners, the problem is not confined to that sector. It has recently become clear that sexual abuse exists in the legal profession, the clergy and other professional groups who operate in trust relationships or unbalanced power relationships.

It is also folly to believe that sexual abuse exists only in the regulated healthcare sector. Although there is only anecdotal evidence to date, sexual abuse of patients is also a problem in the unregulated healthcare sector. Yet, only the healthcare sector, and only regulated practitioners, at that, will be covered by Bill 100.

"There is a concomitant need to address the issue of sexual abuse in the large and growing unregulated healthcare sector and for governments to take concerted and comprehensive action against sexual abuse wherever it occurs."

There is a concomitant need to address the issue of sexual abuse in the large and growing unregulated healthcare sector and for governments to take concerted and comprehensive action against sexual abuse wherever it occurs.

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The Integrity and Efficacy of the Healthcare System ...

A final and overarching objective of the Coalition through this Submission is to help establish a regime that effectively counters sexual abuse, while recognizing the practicalities of healthcare delivery and, most important, that will not diminish the caring and nurturing role of healthcare professionals, or of the healthcare system. No one wants a system where a wall of impersonality is constructed between patient and practitioner; where touch and talk are limited to the minimal clinical essentials.

The education and sensitization of healthcare practitioners and recent media attention to the subject of sexual abuse by healthcare givers, while having very positive effects, has also brought the gender issue to the fore in examinations and has reduced the level of comfort between patient and practitioner, with unintended conse-

quences. Some male physicians have refused to perform pelvic examinations on female patients who present at hospital emergencies unless and until a female practitioner can be found to observe. Some male and female practitioners are insisting on third-party observers during examination of patients of the other sex. Some patients have expressed concern at, what they perceive to be, a diminished rigour in examinations of the pelvic and breast areas by practitioners of the opposite sex. Some practitioners are considering the installation of monitoring and recording systems to guard against unwarranted allegations of sexual abuse.

"The vast majority of regulated healthcare professionals act professionally. In legitimately seeking to counter and eradicate sexual abuse of patients by a small minority of health care givers, the government must avoid setting in motion...the laws of unintended consequences to the overall detriment of our health care system."

The vast majority of regulated healthcare professionals act professionally. In legitimately seeking to counter and eradicate sexual abuse of patients by a small minority of healthcare givers, the government must avoid setting in motion responses that compromise patient privacy, that compromise the practitioner-patient relationship, or that otherwise activate the laws of unintended consequences to the overall detriment of our healthcare system.

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PART III

Specific Issue Areas and Recommendations

It is the consensus of the Coalition members to limit the issue areas addressed in this Submission to five generic subjects:

1. the definition of sexual abuse;
2. mandatory reporting by professionals;
3. intervenor status;
4. the Therapy and Counselling Fund; and,
5. the grafting of Bill 100 on to the **Regulated Health Professions Act.**

Other or related issues may be raised in separate submissions made by individual associations.

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1. Definition of "Sexual Abuse"

a) Commentary

Section 3 of Bill 100 is drafted as follows:

3) In this Code, "sexual abuse" of a patient by a member means,

a) sexual intercourse or other forms of physical sexual relations between the member and the patient;

b) touching of a sexual nature, of the patient by the member; or

c) behaviour or remarks of a sexual nature by the member towards the patient.

4) Subject to the approval of the Lieutenant Governor in Council and with the prior review by the Minister, the Council may make regulations ***clarifying or extending*** *what constitutes sexual abuse of a patient by a member. (emphasis added)*

The definition of sexual abuse is a fundamental issue underlying all of Bill 100 and will be critical to Bill 100's success or failure, because the scope of the Bill and the mandatory reporting requirements it proposes are directly linked to the definition. The Coalition believes the definitional approach proposed by Bill 100 gives rise to six problem areas:

A fundamental concern is the workability of one comprehensive definition of sexual abuse to cover all regulated healthcare groups and the collateral workability of having that single definition interpreted and enforced equitably and fairly by more than twenty regulatory Colleges. Is it possible that one definition can be crafted that, on one hand, is broad enough to cover all twenty-four professional groups, the varying degrees of patient-practitioner dependency and transference that occur and the range of harm that can be inflicted (from embarrassment to profound psychological damage), while on the other hand, tight enough to capture all incidents of sexual abuse that should be covered? Should a massage therapist or a psychotherapist be governed by exactly the same definition as a dentist or chiropodist? For some regulated groups, for example, physical touch or the discussion of sexual subjects are absolutely essential to treatment.[10] For other regulated groups, physical touch and sexual references could reasonably be banned. How can one definition of sexual abuse cover such a wide spectrum?

The problem may be compounded by the judicial review process for College disciplinary decisions contemplated by Bill 100. It may well be that the Courts will take the single definition as compelling evidence that the Legislature intended to treat all professional groups equally under the legislation and did not intend to recognize, what the Coalition sees to be, obvious and bona fide differences among professions.

10. There is a body of research and professional literature on the proven therapeutic value of "touch" in healthcare, including "touch" being particularly useful in treating victims of incest and other forms of sexual abuse. See, for example, "Therapeutic Touch in Mental Health Nursing", Linda Hill, PhD, RN, **Journal of Psychosocial Nursing,** 1993, vol 31, No. 2 which includes selected references.

Should such a scenario come to pass it will result in a level of enforcement under Bill 100 far less than that desired and will tend to capture only incidents of sexual abuse that are obvious or egregious.[11]

"Should such a scenario come to pass it will result in a level of enforcement under Bill 100 far less than that desired and will tend to capture only incidents of sexual abuse that are obvious or egregious."

The Coalition understands that subsection 3(4) was intended to address this definitional problem by allowing each individual College to "clarify or extend" the definition of sexual abuse to adapt the definition to the circumstances and requirements of each profession. The Coalition feels that "extensions" to the definition can appropriately (and perhaps legally)[12] be made only by the Legislature subject to full debate and public scrutiny. On the other hand, the power for each College to "clarify" the statutory definition through regulation is, in the Coalition's view, proper and absolutely essential. Only through such clarifications can each College ensure that the definition is adapted to the special circumstances and requirements of its registrants. Accordingly, while urging the removal of the "extension" power in subsection 3(4), the Coalition strongly advocates retention of the "clarification" power. The removal of the clarification power would, in our view, make the single definition unworkable.

"The removal of the clarification power would, in our view, make the single definition unworkable."

The Coalition understands that some victims' and survivors' groups fear that the "clarification" power - if allowed to remain - could be used by Colleges to narrow or soften the definition to an unacceptable degree and to a degree unintended by the Legislature. Under subsection 3(4) as drafted, all regulations must be approved by the Lieutenant Governor in Council and be subject to the prior review of the Minister of Health. The regulatory process and the public disclosure attached thereto should guard against excessive limitations being placed on the definition and should also ensure the appropriate degree of consistency from College to College.

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11. For a discussion of this point in more detail see "Submission of Simcoe Legal Services Clinic on Bill 100", August 26, 1993, p.p. 2-3.

12. The rule applying to regulations is that regulations must be "within" the powers and limitations defined by the primary legislation (i.e. the Act) and must not be used to extend the powers or "reach" of an Act. Regulation that did so could be held ultra vires by the Courts. To use an analogy often used by administrative law professors, the primary legislation (i.e. the Act) constitutes the skeleton of the law. Regulations can only be used to add flesh to that skeleton, not to add new skeletal appendages or materially change the size and shape of the "skeleton".

Third, the Coalition fears that use of the umbrella term "sexual abuse" to cover all three categories of sexual abuse may trivialize the more serious forms of the offence, namely "intercourse or touching of a sexual nature", compared to other forms of the offence, namely "behaviour or remarks of a sexual nature". This issue, in turn, gives rise to a related issue, that of mandatory reporting at each of the three levels. While mandatory reporting of sexual intercourse and touching of a sexual nature will be readily accepted by practitioners, mandatory reporting of all "behaviour or remarks of a sexual nature" will not receive the same level of understanding or acceptance, thus calling into question the efficacy of mandatory reporting at this level. This issue will be addressed in more detail later in this Submission.

"While mandatory reporting of sexual intercourse and touching of a sexual nature will be readily accepted by practitioners, mandatory reporting of all "behaviour or remarks of a sexual nature" will not receive the same level of understanding or acceptance, thus calling into question the efficacy of mandatory reporting at this level."

"The Coalition proposes that Bill 100 clarify that consent (real or inferred) to sexual relations is not a defence against a charge of sexual abuse."

Fourth, the current definitional formulation in Bill 100 does not address the very difficult issue of consent. One can infer from Bill 100 that commission of any of the actions covered by the definition would automatically constitute sexual abuse, even if consent were apparently given by the patient or inferred by the practitioner. But Bill 100's apparent reliance on inference is not enough. The Coalition proposes that Bill 100 clarify that consent (real or inferred) to sexual relations is not a defence against a charge of sexual abuse.

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"Accordingly, the Coalition agrees that all instances of sexual relations between practitioner and patient are unethical and that because of the power imbalance in the relationship ... consent by the patient will rarely be genuine..."

Since the days of the Hippocratic Oath, sexual contact between physician and patient has been seen as harmful to the patient. While there is evidence that some of the practitioners of alternative therapies, who are removed from the mainstream of regulated healthcare, still assert that sexual relations between patient and practitioner sometimes constitute positive therapy, that view is given no currency by regulated psychotherapy practitioners and by no member of the Coalition. Accordingly, the Coalition agrees that all instances of sexual relations between practitioner and patient are unethical and that because of the power imbalance in the relationship between practitioner and patient, consent by the patient will rarely be genuine:

"The multi-faceted vulnerabilities of the patient create an

enormous power differential, raising questions about the ability (of the patient) to give or withhold informed consent to participate in (sexual relations).[13]

Fifth, Section 3 as drafted does not define what constitutes a "patient", makes no distinction between a current, future or past patient and begs the question as to when a person becomes or ceases to be a "patient".

"...Section 3...does not define what constitutes a "patient", makes no distinction between a current, future or past patient and begs the question as to when a person becomes or ceases to be a "patient"."

This seems anomalous when compared to Bill 100's provisions with respect to mandatory reporting (subsection 85.1-(1)). For mandatory reporting of apparent sexual abuse by a practitioner, another practitioner is required to report only if the latter practitioner:

> " ... has reasonable grounds, **obtained in the course of practising the profession, to believe..."** (emphasis added)

"Defining when a patient ceases to be a patient is very much a factor of the degree of patient-practioner dependence and transference that develop in myraid patient-practitioner relationships."

Because the definition of sexual abuse is not similarly circumscribed, the clear inference is that sexual relations between a practitioner and a current, past or future patient is prohibited.

Defining when a patient ceases to be a patient is very much a factor of the degree of patient-practitioner dependence and transference that develop in myriad patient-practitioner relationships. Obviously, dependence and transference vary greatly across the gamut of healthcare professions. Dependence and transference will also vary within professions and even from procedure to procedure. For example, the level of trust, dependence and transference for a minor, one-time surgical procedure will be much less than that for a long-term therapy for a serious illness. The Coalition believes that the nature of this issue means it is not amenable to addressing through legislation or regulation. The Coalition proposes instead that each College develop clear guidelines for its registrants defining

13. Pope and Bouhoutsos. Ibid, p. 23.

when a person ceases to be, or becomes, a patient for purposes of Bill 100, for the guidance of both practitioner and patient. To ensure an appropriate level of consistency across the gamut of the health-care professional groups, the Coalition proposes that all guidelines be submitted to the Advisory Council on the Regulated Health Professions Act for review and approval.

"The Coalition proposes instead that each College develop clear guidelines for its registrants defining when a person ceases to be, or becomes, a patient for purposes of Bill 100, for the guidance of both practitioner and patient."

Sixth, Section 3 as currently drafted does not address the issue of intent. In fact, the inference of Bill 100 appears to be that commission of any of the acts covered by the definition either demonstrates intent, or that the lack of intent is no excuse. Some victims and survivors' groups assert that the question of intent is a red-herring. They hold that the definitive test should be the impact of the action on the patient, not the intention that lay behind that action. In some categories of sexual abuse, such as intercourse or other physical sexual relations, intent is unambiguous. Such is not necessarily the case with "touching" and even less so with "behaviour and remarks".

"In the Coalition's view, however, behaviour or remarks that unintentionally fall within the definition in the behaviour and remarks category should trigger sensitization, through education (formal or informal), not a mandatory report of sexual abuse."

There is no question that practitioners must be highly sensitive about how behaviour and remarks can be variously felt or interpreted by a wide range of patients in a wide range of situations. In the Coalition's view, however, behaviour or remarks that unintentionally fall within the definition in the behaviour and remarks category should trigger sensitization, through education (formal or informal), not a mandatory report of sexual abuse.

The Coalition has listened with care to victims and survivors' and other groups who assert that the lack of intent should not be a defence against allegations of sexual abuse and that the determining factor should be the impact on the patient. In a brief on Bill 100 prepared by the Simcoe Legal Services Clinic the argument is made that:

"Sexual abuse done with a good will (sic) is just as

destructive as sexual abuse intentionally causing the harm"

and

> "Modifying the definition (of sexual abuse) to include an inquiry into the subjective motivations and intentions of the professional introduces the defects of the failure-prone criminal justice system ... There we decide the offender is not guilty if he did not understand he was raping someone. Here we are in danger of saying the (regulated health professional) is not responsible for his/her actions if s(he) is demeaning or exploiting someone..."[14]

While recognizing the difficulties raised by Simcoe Legal Services, the Coalition would not so readily cast aside the protections afforded by the criminal justice system. The Coalition also asserts that the demonstrated lack of sensitivity or understanding by the regulated health practitioner regarding unintentionally offensive or abusive behaviour or remarks will usually be effectively addressed through counselling and education and does not necessarily call for the procedures and penalties contemplated by Bill 100.

"An honest misunderstanding of what a practitioner meant by a remark or by a certain behaviour should not give rise to a sustained charge of sexual abuse. Nor should a remark or behaviour done by accident, by mistake or inadvertence by a practitioner acting in good faith be categorized as sexual abuse."

Ignoring practitioner intent also ignores the vast potential in to-day's cultural and linguistic mosaic for honest misunderstandings. An honest misunderstanding of what a practitioner meant by a remark or by certain behaviour should not give rise to a sustained charge of sexual abuse. Nor should a remark or behaviour done by accident, by mistake or inadvertence by a practitioner acting in good faith be categorized as sexual abuse.

The Coalition believes that intent should be a critical pre-condition to a finding of sexual abuse by a practitioner in the touching, behaviour and remarks categories, particularly in light of the severity of the

14. Submission of Simcoe Legal Services Clinic, Joint Meeting on Bill 100, August 26, 1993, page 4.

penalties contemplated by Bill 100.[15]

"...intercourse or sexual relations with a patient regardless of harm are unethical, unprofessional and simply wrong."

The Coalition also believes that the extent of harm to the patient must be addressed in any definition of sexual abuse. For sexual abuse to have occurred, there must be harm to the victim and the extent and nature of that harm must be assessed. Harm should not be a condition in the "sexual intercourse" or "physical sexual relations" categories because harm in this category is unarguable, and because intercourse or sexual relations with a patient regardless of harm are unethical, unprofessional and simply wrong.

"...how can harm be assessed on a case-by-case basis?"

There is a distinct lack of empirical data on the extent and nature of harm caused to patients through sexual abuse by healthcare givers. What data there is relates largely to the field of psychotherapy. From anecdotal information, the harm caused appears to range from embarrassment, to confusion, panic, guilt, anger, dysfunctional personal relationships and suicidal tendencies. But how can harm be assessed on a case-by-case basis? In some cases, the patient will repress the incident and show no outward evidence of harm. In other cases, the extent of harm will depend on a number of variables, including the type of abuse inflicted, the victim's personal history, the attitude of the abuser, how quickly therapy is commenced and so on. The Coalition sees the objective assessment of harm to be an important use of expert evidence and testimony before the College panel after a determination of guilt. In any event, notwithstanding the problems and complexities, the Coalition believes that the penalties imposed and the extent to which lack of intent can be used as a defence should be proportional to the degree of harm caused and assessed by experts in the field.

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Finally, the Coalition is concerned about any parts of the definition that have a large subjective element and are, therefore, susceptible

15. In criminal law, under the concept of "mens rea" (literally translated as "the guilty mind"), the intention to commit a criminal offence and the knowledge that it constitutes a criminal offence are necessary preconditions to the finding of guilt.

to wide variations in interpretation. The same remark or behaviour can be seen by one person as being abusive and by another as being completely inoffensive. Many regulated practitioners who deal with the elderly or the infirm routinely assist patients in the removal of clothing, often at the patients' request. Some practitioners hug or pat a patient by way of consolation or encouragement. While completely inoffensive to the parties involved, a third-party observer might feel such behaviour constitutes sexual abuse, or at least insensitive paternalism. Furthermore, how is a practitioner of one profession to judge the behaviour of a practitioner of another profession? There is danger that the accepted clinical practices of a massage therapist or a psychologist, for example, will be misinterpreted by an untutored, but well-meaning, third-party from another profession.

Discussions amongst Coalition members towards trying to devise a workable definition of sexual abuse have illustrated the kind of misunderstandings that could result. Some psychologists (who often hear allegations of sexual abuse) and other professionals were unaware that massage therapists often conduct breast massage, which has proven therapeutic value for lymphatic and other conditions. The scope for honest misunderstandings arising out of such situations must be minimized in any legislation.

For this reason the Coalition does not support the amendments to subsection 3(c) that have been proposed by the Ministry of Health. In our view, the terms "demeaning" and "seductive" (without further definition) are adjectives that are highly subjective and susceptible to wide variations in interpretation. The additions of such adjectives are particularly problematic with third-party reporting, because they increase the burden imposed upon the third-party to interpret either the impact of the behaviour or remarks on the patient, or the intent of the practitioner, in order to have "reasonable grounds" to make a report. Without interviewing either or both the practitioner or patient,

how could a third-party come to such a determination? On the other hand, the Coalition supports the addition of "exploitative", but believes that term should be applied to each of the three categories as discussed below.

b) Recommendation

Addressing each of the issues raised by the Coalition within Bill 100's current conceptual approach to the definition would probably result in a cumbersome definition that raised more interpretive problems than it solved.

Consequently, the Coalition proposes an entirely new approach: The introduction of the concept of "exploitation" as a necessary precondition to the commission of a sexual offence. The exploitation formula gets to the heart of sexual abuse: Sexual abuse represents exploitation of the practitioner's power relationships with the patient and exploitation of the vulnerability of the patient. The exploitation formula is also designed to address the issue of intent, in that exploitation implies active, knowing commission of wrongful action with respect to the "touching", "behaviour and remarks" categories where intent is not unambiguous.

Accordingly, the Coalition proposes amendments to section 3 of Bill 100 in which the exploitation formula is set out, the pre-condition of harm to the patient is added and three categories of the offence are then listed in subsections (a), (b) and (c). The three categories reflect the government's initial proposals as set out in "Taking Action Against Sexual Abuse of Patients". The purpose of the clearer categorization is to draw a more pronounced distinction between the types of sexual abuse covered. These categories should then be appropriately matched with penalties and, as will be discussed later in this Submission, with an appropriate reporting regime for each.

The proposed amendments are as follows:

3. *In this Code, a member is guilty of a sexual offence with respect to a patient if there is any exploitation by a member of the practitioner/patient relationship, by the member's words or actions, in any of the following ways:*

   a) *"sexual violation", namely sexual intercourse or other forms of physical sexual relations between the member and a patient.*

   b) *"sexual transgression", namely touching, of a sexual nature, of a patient by the member that causes harm to that patient; or*

   c) *"sexual impropriety", namely behaviour or remarks of a sexual nature by the member towards the patient that causes harm to that patient.*

The Coalition also proposes that subsection 3(4) be amended by the deletion of the words "or extending". The Coalition is firmly of the view that the remainder of the subsection, namely the "clarification" power, must be retained in order to allow each College to adapt the generic definition to the circumstances and requirements of each profession.

2. Mandatory Reporting by Professionals

a) Commentary

Section 18 of Bill 100 is currently drafted as follows:

*85.1 - (1) A member **shall** file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College,*

   a) *has sexually abused a patient;*
   b) *has committed an act of professional misconduct designated, in the regulations made*

by the Council of that other member's College, as an act of professional misconduct that must be reported;

c) is incompetent; or

d) is incapacitated.(emphasis added)

No single issue is as important to healthcare professionals or to the efficacy of Bill 100 as the issue of mandatory reporting. Bill 100's approach goes to the heart of professional self-regulation and appears to question long-established rights of patient confidentiality and privacy.

"No single issue is as important to healthcare professionals or to the efficacy of Bill 100 as the issue of mandatory reporting."

The issue consists of three facets:

1. Reporting by a practitioner from one profession on a practitioner from another profession and the potential for inter-professional misunderstandings;

2. Reporting an incident of sexual abuse by a practitioner who has learned of the incident through treating the abusing practitioner; and

3. Reporting by practitioners generally.

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Inter-Professional Reporting is problematic in the "touching" and "behaviour and remarks" categories. It requires a practitioner from one healthcare group to pass judgement on the practices of a healthcare practitioner from another group, of whose practices the former practitioner may have little or no knowledge. Should a podiatrist be placed in the position of having to judge whether the treatment by a massage therapist was "of a sexual nature"? Should a physiotherapist be forced to judge whether the behaviour or words of a psychotherapist were "of a sexual nature"? Inter-professional reporting, in the Coalition's view, creates too much scope for well-intentioned, but unwarranted, reporting of practices that are completely accept-

able and have proven therapeutic value in other regulated professions. Inter-professional reporting also implies a level and detail of knowledge of one profession's regulations by practitioners of another profession that simply do not exist, are unreasonable to expect and impossible to enforce.

Practitioner/Patient Confidentiality is a long-established rule within the healthcare community, developed to protect patients' privacy. It is critical to the integrity and performance of our healthcare system. If a practitioner to whom another practitioner guilty of abuse has come for treatment is required to report, the rule has been undermined. In addition, mandatory reporting by treating practitioners will almost certainly deter offending practitioners from seeking and receiving the treatment they require. Avoidance of treatment is contrary to everyone's interests and could lead to an escalation of sexually abusive behaviour by the practitioner in question.

"Inter-professional reporting, in the Coalitions's view, creates too much scope for well-intentioned but unwarranted, reporting of practices that are completely acceptable and have proven therapeutic value in other regulated professions."

In the Coalition's view, mandatory reporting by practitioners will create a major obstacle to self-referral by abusing practitioners. Sexually abusive behaviour is often part of larger problems sometimes experienced by healthcare practitioners, such as addiction. Self-referral for addiction does not trigger mandatory reporting, but any disclosure of sexual abuse of patients as part of the addiction treatment would. As a result, mandatory reporting would tend to reduce self-referral, not only for sexual abuse, but also for a range of problems of which sexual abuse may only be a part. Inter-professional mandatory reporting may, therefore, be counter-productive in achieving Bill 100's objectives to identify the offending practitioner and to arrest the abusive behaviour.

Mandatory reporting of abusing practitioners by treating practitioners also raises the question of whether the treating practitioner's report would be taken to be an admission of guilt by the practitioner. If so, would such a "confession" be used by the disciplinary panel as conclusive evidence of guilt, thus short-circuiting the investigative and

disciplinary process?

In essence, the mandatory regime proposed by Bill 100 fails to make the necessary distinction between third-parties who have themselves seen or heard the offending action and the treating practitioner who has only heard of the incident through treatment. It must be clear that the latter circumstance should not be taken as justification, in itself, for a truncated disciplinary process.

Furthermore, the Coalition does not agree that a practitioner should be required to report if the patient who has been abused refuses to consent to such a report. A requirement to report contrary to the wishes of the patient may be taken as a further manifestation of the powerlessness of the victim and is a clear breach of the victim's right to privacy and to control over his or her own destiny. Furthermore, a victim who has refused consent to a report will unlikely be supportive of or helpful during the investigation and disciplinary process, thereby probably undermining the effectiveness of both. While it is fair to require the practitioner to counsel the patient to report, the Coalition believes that some latitude and discretion must be given to practitioners to report in instances where the patient withholds consent to a report.

Mandatory reporting by practitioners in general is problematic in the "remarks and behaviour" category. Evidence from other jurisdictions where mandatory reporting of all incidents is required under a single definition of sexual abuse indicates that such an approach does not work and leads to avoidance of the legislative or regulatory requirements.[16]

16. The state of Minnesota, USA has in force legislation proscribing "sexual contact" between healthcare professionals and patients. The definition of "sexual contact" has three separate sections relating to a range of sexual relations including various types of intercourse, touching, kissing and language. All licenced healthcare practitioners in Minnesota, as a condition of licence, are required to report any sexual contact by other healthcare practioners, as they are required to report any conduct that may result in disciplinary action or that indicates incompetence.

According to Leonard Boche, M.D. Chief Executive Officer of the Minnesota Medical Licensure Board, since 1985 an average of 19% of reports on breaches of practice standards have come from licenced physicians. This figure fell to 13% in 1992, illustrating an increasing resistance to reporting by practitioners and only 1% of complaints relate to sexual contact. There have been no complaints relating to sexually abusive words used by practioners, in spite of legislation and programs provided by the Board to increase awareness and promote professional reporting.

Because of the mandatory reporting requirements and the penalties that may apply, it is an unfortunate fact of life that a number of healthcare professionals will choose not to see or hear abusive remarks or behaviour, or will give the benefit of the doubt to the perpetrator. As a consequence, many incidents, which should result in a challenge (and in the current environment, usually are) may go unchallenged and the offending behaviour will persist. Such behaviour will progressively undercut the effectiveness of the legislation.

"...many incidents, which should result in a challenge (and in the current environment, usually are) may go unchallenged and the offending behaviour will persist."

There is another issue raised by the current wording of subsection 85.1-(1) and alluded to earlier in this Submission. What is the phrase "... obtained in the course of practising the profession ..." intended to mean? If taken literally, this would mean that one practitioner is required to report only those incidents seen, heard or advised of in day-to-day practice situations.

Does this mean that a member of a profession who becomes aware of an incident of sexual abuse outside of the practice setting is not obligated to report? Must there be a practitioner-patient relationship between the reporting practitioner and the victim to trigger mandatory reporting? Must the practitioner witness the incident, or does heresay evidence trigger the reporting requirement as well? If so, the Coalition has concluded that this formulation contains too much uncertainty and potential for conscious avoidance.

b) Recommendation

The Coalition agrees with mandatory reporting in instances of sexual intercourse or other forms of physical sexual relations between a practitioner and patient. For reasons discussed above, the Coalition feels that mandatory reporting in the "behaviour or remarks" category will be ineffective in achieving the objectives of the Bill. The Coalition proposes a new conceptual approach for responses in this category alone: "The duty to intervene".

A statutory duty to intervene would obligate a practitioner to be proactive in the face of behaviour or remarks of a sexual nature by requiring that practitioner to respond in a way that is appropriate under the circumstances. Pursuant to the Coalition's proposed amendments, a list of responses of increasing gravity would be set out in the statute, from which the practitioner would chose the response or responses most appropriate to the individual circumstance. One of the responses would be a report, as currently envisaged by Section 18, or a report would result if all other responses have been exhausted without achieving the desired result.

"Although many Coalition members feel that mandatory reporting in the "touching" category will generate unwarranted reports, the majority of Coalition members have reluctantly concluded that mandatory reporting should remain for such incidents."

Although many Coalition members feel that mandatory reporting in the "touching" category will generate unwarranted reports, the majority of Coalition members have reluctantly concluded that mandatory reporting should remain for such incidents. The burden will be placed on individual Colleges through guidelines and through regulations pursuant to subsection 3(4) to ensure that therapeutically positive touching is differentiated from sexually abusive touching.

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Finally the Coalition proposes removal of the phrase "obtained in the course of practising the profession". The Coalition feels it must be incumbent upon healthcare practitioners who have direct knowledge of incidents of sexual abuse to respond regardless of how or in what context that knowledge came to them.

The proposed amendments are as follows:

85.7 A member who has reasonable grounds to believe that another member of the same (or a different) College has been guilty of an offence of sexual impropriety[17] as defined by Section 1, Schedule 2(3), has a duty, acting reasonably, in good faith and in the best interests of the patient, to intervene forthwith by:

17. Assumes acceptance of Coalition recommendations on Definition of Sexual Abuse (i.e. Recommendation 1)

a) meeting the member to admonish that member to cease such behaviour, to apologize to the patient, to seek counselling, or to take such other remedial action as the member may consider warranted under the circumstances; and/or

b) offering to mediate between the member and the patient; and/or

c) advising the patient of his or her rights to file a report with the Registrar of the College of the other member; and/or

d) filing a report in accordance with section 85.3.

The Coalition also proposes the addition of a new sub-section authorizing each College to prepare regulations giving guidance to and regulating mandatory reporting by their members of incidents of sexual abuse by a member of another College. These regulations should be submitted in draft form to the Advisory Council on the Regulated Health Professions Act for review and approval to ensure consistency across the spectrum of the professions.

Finally, the Coalition proposes that Bill 100 not require mandatory reporting in instances where the patient refuses to consent to such a report. There should be a duty to advise, counsel or assist the patient in making a report, but the practitioner should be allowed statutory discretion, acting reasonably and in the best interests of the patient, to decide whether a report should go forward.

3. Intervenor Status

a) Commentary

Section 7 of Bill 100 is currently drafted as follows:

41.1 - (1) A panel may allow a person who is not a party to participate in a hearing if,

a) *the good character, propriety of conduct or competence of the person is an issue at the hearing; or*

b) *the participation of the person, would, in the opinion of the panel, be of assistance to the panel.*

2) *The panel shall determine the extent to which a person who is allowed to participate may do so and, without limiting the generality of this, the panel may allow the person to make oral or written submissions, to lead evidence and to cross examine witnesses.*

This Section pertains both to the patient/victim of sexual abuse and to third parties. Each of these two categories of intervenors raises separate issues.

Victims and survivors of sexual abuse believe that the current disciplinary process minimizes or marginalizes their involvement in and impact on that process. These beliefs are not without merit. There is also a misunderstanding by many victims and survivors about how the disciplinary process works and the limitations that have been imposed on that process. In the current self-governing disciplinary system and under that set out in the RHPA, the victim is not a party to the proceeding and is nothing more than a witness. Nor does the College counsel "act" for the victim or the victim's interests.

The regulatory boards' established orientation and procedural requirements are to view allegations of incompetence or misconduct as matters between the board and the practitioner and to see disciplinary proceedings as being between the board and the practitioner. The Royal College of Dental Surgeons of Ontario, in its response to "Taking Action Against Sexual Abuse of Patients" (November, 1992), crystallized that orientation, as follows:

> " ... a disciplinary proceeding is a matter between an individual member and a College. Conceptually, just as a criminal offence is against the Crown, professional misconduct is an "offence" against the College. The individual victim of the offence is an essential witness, but he or she is not a party to the proceeding ..." (Page 8)

Obviously, much more can be done on a College-by-College basis to inform the public and individual victims and survivors how the disciplinary process works and to allow victims and survivors, who choose to do so, to be more involved in, or at least present, during the hearing process and to be allowed and encouraged to participate fully in the pre-hearing procedures. Victims and survivors who have been involved in the current or past disciplinary process should also bear in mind that the long-awaited Proclamation of the RHPA will effect reforms to the disciplinary process that may address at least some of their concerns.

As for third-party intervenors, the wide range of federal, provincial and municipal regulatory bodies routinely allow such persons to have standing before them. A third-party intervenor is someone other than one of the parties to the matter and is usually either a recognized expert in the matter before the regulatory body or has some direct pecuniary or other interest in it. Intervenors are often encouraged to appear before regulatory bodies in order to represent the widest possible spectrum of interests and thus better protect and promote the public interest.

The role to be played by third-party intervenors before a panel of a self-governing regulatory body that is hearing a complaint of sexual abuse is obviously materially different than that applying to most regulatory bodies, but is neither explained nor circumscribed by Bill 100.

The Coalition is concerned that multiple intervenors could be used

intentionally to "overwhelm" either the practitioner or the complainant before a panel; that multiple intervenors will result in dilatory and unnecessarily formalized and lengthy hearings; or that multiple intervenors will generate Court challenges by the accused that vitiate the disciplinary process and routinely overturn its decisions, in some cases letting the guilty go unpunished.

The role to be played by third-party intervenors does not come across clearly in Bill 100. At current College disciplinary hearings, as throughout the justice system, there are two opposing parties. The defendant practitioner is not subjected to the challenge and cross-examination of a third-party, unless that third-party has satisfied the usual legal test of relevance to the proceedings-at-hand. This is a more difficult test to satisfy than the one proposed in Bill 100. Furthermore, unless the Bill specifies criteria that intervenors must satisfy, rather than leaving it to the discretion of each panel, criteria for and the treatment of intervenors will inevitably vary from panel-to- panel and from College- to- College.

b) Recommendation

The Coalition proposes that Section 7 be amended to restrict the participation of non-party intervenors to those who satisfy the accepted legal test of relevance,

- with respect to assisting in the panel's determination of guilt or innocence; or
- to assist or represent victims and survivors who are minors or mentally incompetent;
- with respect to assisting the panel in assessing the emotional or physical damage sustained by the victim upon a finding of guilt; or
- with respect to assisting the panel in determination of the appropriate penalty or penalties following a

finding of guilt and in light of the harm caused and the particular circumstances at play.

4. Therapy and Counselling Fund

a) Commentary

85.7 - (1) There shall be a program, established by the College, to provide funding to persons who, while they were patients, were sexually abused by members. The funding shall be provided to pay for therapy and counselling related to the sexual abuse.

(2) The Patient Relations Committee shall administer the program.

(3) A person is eligible to receive funding only if either,

(a) there had been a finding by a panel of the Discipline Committee that the person, while a patient, was sexually abused by a member; or

(b) such alternative requirements as may be prescribed are satisfied.

"The impact of sexual abuse on patients is often devastating and frequently requires long-term, specialized care."

"The Coalition is opposed to any extension of the Fund beyond counselling and therapy."

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The impact of sexual abuse on patients is often devastating and frequently requires long-term, specialized care. The Coalition agrees, therefore, that funding should be provided to cover all or a portion of the cost of that care. Many victims' and survivors' representatives oppose restriction of the Fund to counselling and therapy and want it to cover "restitution" or "damages" as well. The Coalition notes that although originally referred to as the "Survivors Compensation Fund", it was always the government's intention to restrict payments for coverage of the care required for victims and survivors of abuse[18]. The Coalition is opposed to any extension of the Fund beyond counselling and therapy.

18. See "Taking Action Against Sexual Abuse of Patients, Ibid, p. 16.

The Coalition notes, in this regard, that patients who allege sexual abuse by a healthcare practitioner are in no way precluded from seeking "restitution" or "damages" through a civil suit, from applying to the Criminal Injuries Compensation Board, or from making use of a range of civil or criminal remedies.

"...patients who allege sexual abuse by a healthcare practioner are in no way precluded from seeking "restitution" or "damages" through a civil suit, from applying to the Criminal Injuries Compensation Board, or from making use of a range of civil or criminal remedies."

The Coalition also understands victims' and survivors' concerns that funding can be provided for therapy and counselling received only after a finding of guilt. The Coalition supports allowing for payment for counselling or treatment obtained as a consequence of the abuse before the date upon which a ruling of guilt was issued.

"The Coalition supports allowing for payment for counselling or treatment obtained as a consequence of abuse before the date upon which a ruling of guilt was issued."

The Coalition has several of its own reservations about the Fund as proposed in Bill 100:

A fundamental concern is that sexual abuse arising from fiduciary or unbalanced power relationships is demonstrably not restricted to the healthcare sector. Funding for treatment and counselling should be universally available to victims and survivors of such abuse and should be available from public funding.

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"Funding for treatment and counselling should be universally available to victims and survivors of such abuse and should be available from public funding."

The Coalition recognizes the fiscal implications of such comprehensive funding, particularly in the current fiscal environment. We also recognize that funding would have to reflect jurisdictional responsibilities. For example, in Ontario, public funding might be restricted to those self-governing professions under provincial jurisdiction. Furthermore, we recognize that the goal of universal funding is not practically achievable overnight and we accept that as good a starting point as any is the healthcare sector.

The Coalition, however, urges the government not to lose sight of the wider funding need and to perceive Bill 100's Therapy and Counselling Fund as only a first step towards a more comprehensive fund.

For the time-being, however, we shall restrict our comments to the Fund as envisaged by Bill 100.

The Coalition does not support financing the Fund through individual College levies on registrants. Since passage of the **Canada Health Act** in 1965, Canada and Ontario have been committed to quality healthcare that is government-funded and delivered on a universal, no-fault basis. These have been basic principles underlying our healthcare system and the Coalition feels that sufficient cause has not been demonstrated to depart from them for this particular category of treatment. Research indicates,[19] furthermore, that victims and survivors of abuse frequently have a history of abuse. Accordingly, the treatment will, in these cases, pertain not just to one incident, but to a history of abuses from several sources and pre-dating the abuse by the healthcare practitioner. When seen in this context, treatment funding should be more broad-based and not be limited to treatment for one specific incident of sexual abuse.

"...the treatmant will, in these cases pertain not just come to one incident, but to a history of abuses from several sources and pre-dating the abuse by the healthcare practioner."

Each of the members of the Coalition recognizes the collective responsibility of each professional and the profession as a whole for the conduct of individual practitioners of their professions. That collective professional responsibility includes setting, monitoring and enforcing standards of practice through financially supporting the regulatory function. It does not extend to covering the cost of treatment for patients mistreated in some way by practitioners. The Therapy and Counselling Fund contemplated by Bill 100 takes collective professional responsibility into new and uncharted territory, by imposing a levy on the vast majority of healthcare practitioners to fund counselling and therapy resulting from the aberrant behaviour

"The Therapy and Counselling Fund contemplated by Bill 100 takes collective professional responsiblity into new and uncharted territory."

19. Ibid, p. 16.

20. In her speech in the Legislature to open the Second Reading debate on Bill 100, the Hon. Ruth Grier said: "I want to make it clear that while there are far too many horror stories, I believe that the vast majority of health professionals are providing sound, trustworthy and nurturing care, but the government has an obligation to provide protection against the minority who do not."
(Legislative Assembly of Ontario, 29 July, 1993, p. 2979).

In this regard, the Coalition notes that fines paid by practitioners will be paid to the Consolidated Revenue Fund, not to any Fund. The result, in effect, is that the "innocent" practitioners are required to pay for victim treatment and therapy, while the "guilty" practitioner contributes to general government revenues. In the Coalition's view, penalties should be paid directly into a Fund.

"The result, in effect, is that the "innocent" practioners are required to pay for victim treatment and therapy, while the "guilty" practitioner contributes to general government revenues."

There are large variations in the number of practitioners from profession to profession in Ontario. For example, while there are 22,200 medical doctors practising in Ontario, there are 86 podiatrists. Average incomes also vary widely from profession to profession, with some professions averaging as low as $35,000.00 annually and others in excess of $100,000.00 annually. The difference in memberships and income levels will result in either an unduly heavy burden imposed on some healthcare groups to finance the Fund, or vast differences in Fund capacity from group- to -group. If an undue financial or regulatory burden is placed on certain professions, it may lead to the voluntary withdrawal of an untold number of practitioners from regulated practice in those professions. This would potentially be the case for those regulated professions who have very limited authorized acts under the RHPA and for those professionals who can continue to practise unimpaired in the unregulated sector. The professions of psychotherapy, massage therapy and physiotherapy are examples of professions where potential for such erosion exists. Such a trend would be counter-productive in achieving the much wider objectives of the RHPA.

"The Coalition is concerned that individual College administration, especially when coupled with the capacity issue, will inevitably result in differing treatment of victims and survivors from College-to-College."

The Coalition notes that each College Patient Relations Committee is to administer that College's Fund. The Coalition is concerned that individual College administration, especially when coupled with the capacity issue, will inevitably result in differing treatment of victims and survivors from College- to -College. The Coalition is firmly of the belief that equal treatment of victims and survivors across the

the belief that equal treatment of victims and survivors across the gamut of regulated healthcare professions is absolutely essential. A related issue is the extent to which there may be a real or perceived conflict of interest in a College having the responsibility to determine guilt, the extent and nature of the penalties to be levied and disbursements from the Fund for counselling and therapy on a case-by-case basis. While there is no question of an obligation to investigate and discipline, the disbursement of funds for therapy and counselling by a regulatory board represents a major departure from the accepted and established role of regulatory boards.

Finally, Bill 100 as drafted contemplates no restrictions on the types of counselling or therapy or the therapists or counsellors to which money from the Fund may be channeled. The Coalition is strongly of the view that the Fund should not pay for therapy or counselling by unregulated healthcare practitioners. In the regulated healthcare sector, standards have been established and accountability is enforced. Such is the not the case in the unregulated sector. Neither the government nor the regulatory Colleges have any control over or accountability from the myriad unregulated healthcare practitioners. We feel that in many cases, particularly in the field of psychotherapy, treatment or counselling in the unregulated sector could be ineffective, counter-productive and perhaps further risk the health of the patient. Consequently, we feel that the government should rethink any initiative that channels patients to, or subsidizes treatment in, the unregulated sector. It makes something of a mockery of the Regulated Health Professions Review if the government is to put in place a mechanism that directs or condones the direction of patients to the unregulated sector. By channeling patients into, or condoning the treatment of patients in, the unregulated sector, the government is effectively abandoning the responsibility and principles of public protection and practitioner accountability that underlie the RHPA.

"The Coalition is strongly of the view that the Fund should not pay for therapy or counselling by unregulated healthcare practioners"

"We feel that in many cases, particularly in the field of psychotherapy, treatment or counselling in the regulated sector could be ineffective, counter-productive and perhaps further risk the health of patients."

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If the counselling and treatment funds are required to cover all or part of the cost of treatment in the unregulated sector, the Coalition feels it incumbent upon the government to assume responsibility for the quality of care delivered to victims and survivors by unregulated healthcare practitioners.

For our part, regulated health professionals are very aware from a wealth of experiences of the totally valueless, counter-productive and even harmful therapies and counselling that are offered and routinely provided in the unregulated sector. In the unregulated sector there are wild variations in and no mechanism to assess training, qualifications, ethical and competence standards. Few unregulated practitioners will have the requisite liability or malpractice insurance to cover misadventures. Accordingly, members of the Coalition are very reticent about subsidizing or implying support for therapies, in the unregulated sector that may, in effect, continue and amplify the abuse to the patient.

"...regulated health professionals are very aware from a wealth of experiences of the totally valueless, counter-productive and even harmful therapies and counselling that are offered and routinely provided in the unregulated sector."

The regulated healthcare sector is increasingly proficient in treating victims and survivors of sexual and other forms of abuse. In some regulated practices, abuse victims and survivors account for up to 40% of patients. Many individual regulated practitioners are long-time, highly-active members of victim's groups and some regulated practitioners are themselves survivors of sexual abuse by healthcare practitioners. The regulated sector as a whole is neither insensitive to nor untutored in the needs of the sexually abused.

"The regulated sector as a whole is neither insensitive to nor untotored in the needs of the sexually abused."

b) Recommendations
The Coalition recommends:

a) that there be one Fund for the treatment of victims and survivors of sexual abuse by healthcare practitioners and that a single Fund cover all regulated healthcare sectors;

b) that the fund be financed from general government revenues;

c) that a single expert board administer allocations from the Fund to persons upon a finding that said persons were victims of sexual abuse while a patient of a healthcare practitioner;

d) that treatment or counselling of a victim by an unregulated healthcare practitioner not be eligible for funding, in whole or in part, from the Fund; and

e) that disbursements from the Fund could retroactively cover treatment and counselling obtained prior to a panel's determination of guilt.

5. Stand-Alone Legislation

a) Commentary

This Submission has already discussed the several anomalies raised and problems created by grafting legislation of this type on to the **Regulated Health Professions Act**: restriction of the ambit of the legislation to the regulated healthcare sector; the use of the established self-governing regulatory procedures and processes to handle allegations and penalties; of real or perceived conflicts of interests by Colleges in determining guilt, levying penalties and making disbursements from the counselling and treatment Fund; and the clear inference that sexual abuse in unbalanced power relationships is restricted to the regulated health sector.

In addition, the Coalition fears that the RHPA may become a legislative straight-jacket for Bill 100 and freeze in time the legislative framework on sexual abuse by practitioners. As stated previously, the Coalition is strongly of the view that Bill 100 is only the beginning of the process; that Bill 100 must be open to periodic refinement and improvement as experience and circumstances dictate.

The Coalition notes that the Health Professions Legislative Review Process, from which the RHPA resulted, has been on-going for over

Coalition also recognizes that the exigencies of government and the work-load placed upon the Legislature will make any government reticent about opening the RHPA for amendment on any but the most important and pressing matters.

The Coalition is also concerned about the ability of the existing self-governing regulatory structure to be able to respond effectively - and be seen to respond effectively - to the requirements of Bill 100, in terms of handling complaints in an expeditious, fair and equitable manner. A suggestion considered by the Coalition was the creation of one quasi-judicial tribunal that would handle all complaints of sexual abuse in a way at least similar to procedures in the civil and criminal Courts. Ultimately, the Coalition rejected this suggestion fearing that, to set up a single tribunal would simply duplicate civil or criminal remedies and procedures. Equally important, the Coalition saw no way that one tribunal could be expected to appreciate and apply real practical differences among professions as to that which constitutes sexual abuse.

b) Recommendation

The Coalition recommends:

- that Bill 100 be separated from the **Regulated Health Professions Act** and go forward and be proclaimed as an Act in its own right; and

- that a clause be added to Bill 100 requiring its referral to a Standing Committee of the Legislature for review and public hearings within two (2) years of Proclamation of Bill 100.

In this way furthermore, Bill 100 could be used as a base to build an effective legislative regime to counter sexual abuse by a range of provincially-regulated, self-governing professionals (e.g. teachers, police, social workers, lawyers, the clergy etc.)

PART IV

Conclusion

Regulated healthcare professional associations who constitute the Coalition recognize that sexual abuse of patients by practitioners demands prompt and effective remedial action because of the often devastating and pervasive impact of the abuse on the patients. Coalition members acknowledge that they, as associations and the members they represent, could have done more to understand and confront the true nature and extent of the problem. Having now done so, at least at the association leadership level, Coalition members wish to be a full partner in the solution.

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One objective of Bill 100 is to ensure that sexually abusive healthcare practitioners are identified and penalized. Mandatory reporting by other healthcare practitioners constitutes a major component in achieving that objective. Mandatory reporting will work most effectively if the legislation is seen to be an appropriate and balanced response to the problem, if it is seen to be fair and does not intrude upon or unduly impair the patient-practitioner relationship, the patient's right to privacy or the patient's control over his or her own life.

Another objective of Bill 100 is to deter sexually abusive behaviour by healthcare practitioners. The principal deterrent, to use the Minister of Health's words, is

> "... to make healthcare professionals ... aware that if the trust between a patient and practitioner is abused, the consequences will be serious."[21]

The "consequences" proposed by Bill 100 are severe penalties that (with the exception of incarceration) equal or exceed those authorized for the Courts under the **Criminal Code.**

The Coalition supports severe penalties for healthcare practitioners

21. **Legislative Assembly of Ontario**, 29 July, 1993, pg. 2979.

found guilty of sexually abusing a patient. The Coalition believes, however, that the severity of the penalties calls for at least some of the protections and procedures afforded to the accused in the criminal justice system. The Coalition also believes there are many improvements that can be made to Bill 100 to safeguard the rights of the victim and enhance the victim's impact on the disciplinary process.

Another objective of Bill 100 is to look out for the interests of the victims and survivors, to guard against revictimization, to give victims and survivors effective recourse and assist in the therapy and counselling required for recovery.

These are the objectives of Bill 100 as stated by the Minister of Health at the opening of the Second Reading debate in the Legislature.

The Coalition is in complete agreement with each of these objectives. We approached our review of Bill 100 and evaluated each part of Bill 100 against these objectives. The recommendations we have made in this Submission, after extensive and invaluable consultations with victims and survivors, victims' and survivors' groups, the regulatory boards, MPP's and government officials, are designed to improve the workability and effectiveness of Bill 100 in achieving these objectives.

The Coalition believes that Bill 100 is only one step towards addressing the problem of sexual abuse. Much remains to be done in the education and sensitizing of our memberships, in continuing to consult with, learn from and share experiences with victims and survivors and healthcare consumers; in educating and communicating with the public; in setting and enforcing guidelines on permissible practitioner-patient behaviour. And much remains to be done to address the entrenched behaviourial patterns that lead to and condone sexual abuse across all sectors and throughout all levels of our society.

This Submission is respectfully submitted by the following healthcare associations who together comprise the ad hoc Coalition of Regulated Healthcare Associations on Bill 100:

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Kenneth Battell
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Sharyn Joliat
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Dr. Ruth Berman, Ph.D., C.Psych.
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Evelyn Tassios
Chair, Legislative Affairs Committee
The Ontario Association of Speech-Language Pathologists and Audiologists

ANNEX A

List of Meetings/Consultations

Victim/Survivor Groups:

April 3, 1993

June 3, 1993

July 15, 1993

July 23, 1993

August 26, 1993

October 28, 1993

Ministry of Health:

April 16, 1993

May 26, 1993 (meeting with Minister of Health Ruth Grier)

June 3, 1993

June 16, 1993

July 15, 1993

August 26, 1993

MPP's:

July 19, 1993 - Barbara Sullivan, M.P.P.

July 22, 1993 - Jim Wilson, M.P.P.

Other Professions:

May 20, 1993 - Ontario Teachers' Federation

May 20, 1993 - Canadian Bar Association, Health Law Section

May 20, 1993 - Ontario Association of Professional Social Workers

ANNEX B

Selected Bibliography

Berger, E. and Stoisey, N, "Initial Analysis of a Survey of Ontario Women regarding Sexual Harassment and Abuse by Ontario Physicians", **Canada Health Monitor**, Toronto, October 27, 1991.

College of Physicians and Surgeons of British Columbia, "Crossing the Boundaries", November, 1992.

Environics Research Group Limited, "**The Ontario Medical Association Survey**, Toronto, December, 1991.

Hazelwood R., Warren J. and Dietz P., "Compliant Victims of the Sexual Sadist", **Australian Family Physician**, Vol. 22, No. 4, April, 1993.

Hill, Linda, "Therapeutic Touch in Mental Health Nursing", **Journal of Psychosocial Nursing.** Vol. 31, No. 2, 1993.

Irons, R., "Assessment of the Sexually Exploitative Professional"

McKenna, Jody, "Some Arguments and Positions on Bill 100", Paper presented to Joint Meeting on Bill 100, Toronto, August 26, 1993.

METRAC, "Recommendations to the College of Physicians and Surgeons of Ontario", (undated)

Ministry of Health (Ontario), "Consolidated Report: RHPA, Bill 100 and Proposed Government Amendments", August 10, 1993.

Ministry of Health (Ontario), "Consolidated Report: RHPA, Bill 100 and Proposed Government Amendments", October 17, 1993

Minnesota Statutes, SF No 1619, Chapter No. 372

Pope, K.S. and Bouhoutsos, J. **Sexual Intimacy Between Therapists and Patients,** Praeger, New York, 1986.

Royal College of Dental Surgeons of Ontario, "Response to Taking Action Against Sexual Abuse", November, 1992.

Simcoe Legal Services Clinic, "Submission to Joint Meeting on Bill 100", Toronto, August 26, 1993.

Stone, Alan A. "Sexual Misconduct by Psychiatrists: The Ethical and Clinical Dilemma of Patient Confidentiality", **American Journal of Psychiatry,** 140:2, February, 1983.

Webb, W.L. "The Doctor-Patient Covenant and the Threat of Exploitation", **American Journal of Psychiatry**, 143:9, September, 1986.

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